STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003000	A. BUILDING: _____ B. WING _____	10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINGSTON AT DUPONT	1716 E DUPONT RD FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Licensure Survey. Survey dates: October 2, 3, 2013 Facility number: 003000 Provider number: N/A Survey team: Tim Long, RN-TC Carol Miller, RN Rick Blain, RN Census bed type: Residential: 37 Total: 37 Census Payor type: Other: 37 Total: 37 Kingston at Dupont was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality Review 10/04/13 by Lisa McColly	R 000		